

CATHOLIC DIOCESE OF LANSING
Office of Vocations

228 N. Walnut, Lansing, Michigan 48933

Parent/Guardian Permission Form for Field Trips

Dear Parent or Legal Guardian,

Your son is eligible to participate at this Diocesan sponsored event which may require transportation to a location away from the parish grounds; therefore if your son is under the age of 18, this form needs to be returned to the Vocation Office. This visit will take place under the guidance and supervision of Fr. John Whitlock, Director of Seminarians/Office of Vocations.

The date of the **Annual Bishop's Discernment Dinner is Sunday, August 22, 2021**

Place: St. Francis Retreat Center, Bethany House, DeWitt
Time: 3:00p-5:30p
Transportation type: Arranged through each Parish
Meals: BBQ Dinner and Snacks

Please read and mark the appropriate boxes as they apply.

Yes* - My son has a food allergy /or special dietary needs. Please notify Denise/Administrative Assistant to Office of Vocations. Email: ddellacqua@dioceseoflansing.org

***An emergency contact for him:**

Name _____ Phone: _____

Address _____ Email: _____

Relationship: _____

I understand the event described above, including all the details mentioned. I consent to my son's participation to St Francis Retreat Center in DeWitt, MI. I understand that no event, including the one described above, is without risk of injury. Nevertheless, on behalf of myself and my son, I voluntarily waive any liability of any sort that might arise on the part of the Catholic Diocese of Lansing Office of Vocation, or any, employee, volunteer, agent, chaperone, parent, or student in connection with this event. My signature attests to my understanding, consent, and waiver, as set forth in this paragraph.

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

Parent/Guardian's Signature _____ Date _____

Print Name _____ Phone _____

Name of Contract Provider _____

Insurance Health Plan _____ Health Plan Contract Number _____